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BEYOND TRADITIONAL VISION CARE

IMPORTANT: *The information on this intake form will enable the doctor to ascertain and evaluate your child's needs most effectively. Please fill out the following as completely as possible and* ***PLAN 2 HOURS*** *for the initial examination. We look forward to meeting you!*

INSTRUCTIONS: *1) Using your computer, you may type directly on this form.* ***PRINT A HARD COPY*** *in case there are e-mail submission issues. E-mail the form to us by clicking the "submit" button OR, 2) print this form and write the information directly in the spaces provided. Fax or mail the completed form to the fax number or address in the upper right-hand corner. PLEASE forward any other pertinent records to our office after this form has been submitted.*

I. Child's Information

Last name First Called by

Birth date Month Day Year Age ☐ Male ☐ Female

Street address

City State Zip

Home phone ( )

School Grade

Favorite subjects Least favorite subjects

Referred by?

II. Present Situation

Please describe the reason for this visual processing evaluation. (For instance, who first noticed the child's problem and when?)
Type here:

Did the problem occur suddenly?
Type here:

Do your child's problems seem to be related to illness, accident, or other trauma?
Type here:

Ordinal position of child (i.e. 3rd of 6 = 3/6) Number of household moves in child's lifetime?

Academic problems:	None	Moderate	Severe
Reading	☐	☐	☐
Spelling	☐	☐	☐
Writing	☐	☐	☐
Arithmetic	☐	☐	☐

Academic problems:	None	Moderate	Severe
Science	☐	☐	☐
History	☐	☐	☐
Foreign language	☐	☐	☐
Physical education	☐	☐	☐

Other, specify: What do you feel is the reason(s) for these problems?
Type here:

II. Present Situation (continued)

Additional comments on problems in school or history? (Example: can't learn letters and sounds, always reverses letters)
Type here:

Regular attendance? ☐ Yes ☐ No Did child ever repeat a grade? ☐ Yes ☐ No If yes, which?

Does child like school? ☐ Yes ☐ No Teacher? ☐ Yes ☐ No Fellow students? ☐ Yes ☐ No

Has your child had any remedial work? ☐ Yes ☐ No When?_____

In what? Effects?

Age of entrance into first grade _____ yrs. _____ months

Organization:	**Yes**	**Sometimes**	**No**		**Yes**	**Sometimes**	**No**
Fails to plan for homework	☐	☐	☐	Trouble keeping on task	☐	☐	☐
Does not finish attempted tasks	☐	☐	☐	Seeks excessive attention/help	☐	☐	☐
Disorganized, messy work	☐	☐	☐	Misjudges time	☐	☐	☐
Disorganized, messy room	☐	☐	☐	Misjudges space	☐	☐	☐

Play and Sports Activities:	**Yes**	**No**		**Yes**	**No**
Does child have pet?	☐	☐	Participate in rhythm activities	☐	☐
Does child assume responsibility for pet?	☐	☐	(jump rope, dancing, patty cake, etc.)		
Does child voluntarily use books & magazines?	☐	☐	Participate in ball activities	☐	☐
Does child like to be read to?	☐	☐	(baseball, basketball, etc.)		
Does child hold book when being read to?	☐	☐	Does child like legos and puzzles	☐	☐
Listen to music?	☐	☐	Does child prefer indoor activities	☐	☐

Motor Control:

Which hand does your child prefer for writing? ☐ Left ☐ Right Always? ☐ Yes ☐ No

Does your child have an awkward gait? ☐ yes ☐ No

Is your child clumsy? ☐ yes ☐ No

Is your child skillful with his/her hands? ☐ yes ☐ No

Foods:

Please list foods your child likes and foods that are avoided or disliked.

Likes

Type here:

Disliked or avoided

Type here:

III. Behavior Characteristics

	Never	Sometimes	Often
Awareness:			
Inattentive to what others say	☐	☐	☐
Preoccupation in his/her own world	☐	☐	☐
Day-dreams	☐	☐	☐
Disoriented and confused	☐	☐	☐
Short attention span	☐	☐	☐
Distractable	☐	☐	☐
Personality:			
Feeling of inferiority	☐	☐	☐
Easily led by others	☐	☐	☐
Lacks self-confidence	☐	☐	☐
Shy, bashful, easily embarrassed	☐	☐	☐
Nervous, jittery, jumpy	☐	☐	☐
Anxious (fearfulness)	☐	☐	☐

Specific fears _____

	Never	Sometimes	Often
Attitude:			
Fighting, hot-tempered	☐	☐	☐
Negative attitudes	☐	☐	☐
Profane language	☐	☐	☐
Disruptive	☐	☐	☐
Destructive	☐	☐	☐
Irresponsible - undependable	☐	☐	☐
Attention-seeking (shows off)	☐	☐	☐
"Know-it-all" attitude	☐	☐	☐
Tense, uptight	☐	☐	☐
Uncooperative	☐	☐	☐
Boisterous, rowdy	☐	☐	☐
Impertinent, saucy	☐	☐	☐
Tendency to annoy others	☐	☐	☐
Hyperactivity (always on the go)	☐	☐	☐
Lacks enthusiasm	☐	☐	☐
Sleeping / Activity:			
Restless while awake	☐	☐	☐
Requires frequent naps	☐	☐	☐
Restless during sleep	☐	☐	☐
Difficulty getting to sleep	☐	☐	☐
Does not get enough sleep	☐	☐	☐
Needs large amount of sleep	☐	☐	☐
Extreme fatigue	☐	☐	☐
Awakens tired and slow	☐	☐	☐
Irregular arising time	☐	☐	☐
Eating:			
Finicky eater	☐	☐	☐
Irregular elimination habits	☐	☐	☐
Eats large amount of sweets	☐	☐	☐
Eats rapidly	☐	☐	☐
Bites nails	☐	☐	☐

Additional comments:
Type here:

IV. Pregnancy and Delivery History

During Pregnancy	Yes	No
Was child active in utero?	☐	☐
Blood incompatibility (RH)	☐	☐
Hemorrhage	☐	☐
Usage of internal medications during pregnancy	☐	☐
Barbiturates?	☐	☐
Hallucinogenics?	☐	☐
Excessive alcohol?	☐	☐
Labor - spontaneous with no complications?	☐	☐

If no, please explain
Type Here:

	Yes	No
Adequate and regular nutrition during pregnancy?	☐	☐
Toxemia (blood poisoning)	☐	☐
Major illness or trauma	☐	☐
Pelvic x-rays	☐	☐
Other abnormalities	☐	☐
If yes, what? _____		
Excessive smoking?	☐	☐

Type of delivery: Baby position at birth:

IV. Pregnancy and Delivery History (continued)

Labor and Delivery:

Length of Pregnancy (weeks) _____ Birth Weight _____ lbs. _____ oz. Length _____ in.

After Birth:	Yes	No		Yes	No
Blood exchange transfusion	☐	☐	Severe Jaundice	☐	☐
Anoxia (lack of oxygen)	☐	☐	Resuscitation	☐	☐
Incubator after birth	☐	☐	Seizures	☐	☐
Poor sucking	☐	☐	Abnormal cry	☐	☐
Cord around neck	☐	☐	**Others, specify:** _____		

V. Child's Early Medical History

Past Illnesses:	Yes	No	Age		Yes	No	Age
Head trauma	☐	☐	_____				
Convulsions or seizures	☐	☐	_____	Reactions to drugs, vaccine allergies	☐	☐	_____
Diabetic	☐	☐	_____	Allergies - what? _____	☐	☐	_____
Asthma	☐	☐	_____	Severe ear infections	☐	☐	_____
High fever	☐	☐	_____	Hospitalization - If yes, for what?	☐	☐	_____
Serious infections or injury	☐	☐	_____	_____			
				Frequent respiratory infections	☐	☐	_____
Broken bones? (Describe)				Other _____	☐	☐	_____

Are there any medications the child is taking frequently? If yes, for what purpose?
Type here:

VI. Development History

Information obtained from: Baby book ☐ Other records ☐ Memory ☐

	Norm	**Early**	**Average**	**Slow**	**Comments:**
Teething:					
2 lower central incisors	6-9 Mo.	☐	☐	☐	
4 upper lateral incisors	8-12 Mo.	☐	☐	☐	
First permanent teeth	5-6 Yrs.	☐	☐	☐	
Gross Motor:					
Were there any problems in neck control development?	4 mo.	☐	☐	☐	
Sitting alone	8 Mo.	☐	☐	☐	
Crawling alone	9 Mo.	☐	☐	☐	
Unusual crawl pattern (describe) _____					
Stand alone	15 Mo.	☐	☐	☐	
Walk alone	15 Mo.	☐	☐	☐	
Fine Motor:					
Elimination: bowel control	12-24 Mo.	☐	☐	☐	
Bladder control	2-3 Yrs.	☐	☐	☐	
Dressing / buttoning clothes	4 Yrs.	☐	☐	☐	
Lacing shoes	5 Yrs.	☐	☐	☐	

Emotional trauma? (loss of grandparent, pet, divorce, etc.) Describe: _____

Speech - Auditory History

		Norm	Early	Average	Slow	Comments:
Speech:	Syllables	6 Mo.	☐	☐	☐	
	Da-da, etc.	9 Mo.	☐	☐	☐	
	2 words	12 Mo.	☐	☐	☐	
	4 words	15 Mo.	☐	☐	☐	
	Short sentences	24 Mo.	☐	☐	☐	
	Gives full name	30 Mo.	☐	☐	☐	

Was or is speech delayed?	☐ Yes	☐ No	Does child reply appropriately to simple directions and questions?	☐ Yes	☐ No
Is speech clear?	☐ Yes	☐ No			
Can child express his thoughts clearly?	☐ Yes	☐ No	Does he ask for frequent repetitions of conversations or instructions?	☐ Yes	☐ No
Does child turn his head to one side to listen?	☐ Yes	☐ No			
Does child often say "huh"?	☐ Yes	☐ No	Does he have to look at you to understand what you say?	☐ Yes	☐ No
Does child omit of parts of words?	☐ Yes	☐ No			
Does child "baby talk"?	☐ Yes	☐ No	Is speech understandable by persons outside of family?	☐ Yes	☐ No
Does child stutter?	☐ Yes	☐ No			
Is speech understandable by family?	☐ Yes	☐ No	Does he/she repeat television Commercials, jingles, etc.?	☐ Yes	☐ No
Is there a bilingual parent?	☐ Yes	☐ No			
What other language(s) are spoken at home?			If given a list of things, can he/she bring back the correct items?	☐ Yes	☐ No
Type here:					

Visual History

Has the child had any unusual visual attention or care? ☐ Yes ☐ No Describe: _____

Does child have glasses now? ☐ Yes ☐ No Does child wear them? ☐ Yes ☐ No

If yes, when should child wear them? _____

Have child's lenses been changed? ☐ Yes ☐ No How often? _____

Does the child complain of:	Yes	Sometimes	No
Headaches	☐	☐	☐
Blurred vision (far)	☐	☐	☐
Blurred vision (near)	☐	☐	☐
Double vision	☐	☐	☐
Eye strain	☐	☐	☐
Bright lights	☐	☐	☐
Other _____	☐	☐	☐
Have you noticed the child:			
Rubbing eyes	☐	☐	☐
Developing sties	☐	☐	☐
Often blinking excessively	☐	☐	☐
Having red eyes	☐	☐	☐
Sitting too close to the TV	☐	☐	☐
Other _____	☐	☐	☐

Does the child:	Yes	Sometimes	No
Reverse letters	☐	☐	☐
Reverse words	☐	☐	☐
Skip or repeat words	☐	☐	☐
Keep place with finger	☐	☐	☐
Move lips	☐	☐	☐
Move head excessively	☐	☐	☐
Lose place on page	☐	☐	☐
Close or cover one eye	☐	☐	☐
Tilt or turn head	☐	☐	☐
Distort face muscles	☐	☐	☐
Have an awkward posture	☐	☐	☐
Maintain concentration for a long period of time?	☐	☐	☐

Any other information? (example: When and how often do these symptoms occur?)
Type here:

VII. Previous Evaluations (i.e. speech and hearing, psychological, neurological)

Reason?

By whom Date

Address

Reason?

By whom Date

Address

Please request copies of all previous evaluation reports be sent to us prior to evaluation date to complete our history of your child.

VIII. Parent or Guardian Information

Father's [or Guardian] name Mobile phone

Street address [if different from Child's]

City State Zip

Home phone Work phone

E-mail Occupation or position

Mother's [Guardian] name

Street address [if different from Child's]

City State Zip

Home phone Work phone

E-Mail Occupation or position

Signature Date

We will ask you to sign this form at your first visit.

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A small photo is useful for our files. Please bring one with you to the examination OR insert a digital image. For successful e-mailing capacity It must be 150K or less @ 72dpi.

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